MULTIPLE CHOICE

1. The term old age or aged can best be defined as:

a. Person’s state of mind
b. Person older than 65 years of age
c. Process of growing older
d. Person of advanced age

ANS: D

Aged or old age is defined advanced in years.

DIF: Cognitive Level: Comprehension REF: p. 142 OBJ: 2
TOP: Definitions of Old Age KEY: Nursing Process Step: N/A
MSC: NCLEX: N/A

2. Aging is recognized by gerontologists as a developmental process that:

a. Is measured in chronologic years.
b. Is directly related to heredity.
c. Relates to behavioral characteristics.
d. Begins at the time of birth.

ANS: D
Geriatrics is the science of old age and the application of knowledge related to the biologic, biomedical, behavioral, and social aspects of aging. DIF: Cognitive Level: Knowledge REF: p. 142 OBJ: 2

TOP: Definitions of Old Age KEY: Nursing Process Step: N/A

MSC:NCLEX: N/A

3. Prerequisites for the nurse working with the geriatric patient include an understanding that:

a. Specialized knowledge is needed.
b. The geriatric patient will be physically impaired.
c. Most geriatric patients will develop dementia.
d. The geriatric patient will need to be closely supervised.

ANS: A

Knowledge, understanding, and caring are prerequisites for working effectively with older adults. Although specialized formal education programs at the graduate level are available for gerontologic nurses, many nurses gain special skills through on-the-job experiences.

DIF: Cognitive Level: Comprehension REF: p. 143 OBJ: 1

TOP: Roles of the Gerontologic Nurse KEY: Nursing Process Step: N/A

MSC:NCLEX: N/A

4. A 78-year-old resident of a long-term care facility insists on wearing high heels and miniskirts to the dining room for meals and will not leave her room without first applying glamorous makeup. The gerontologic nurse assesses that the behavior is related to:

a. Insecurity about her appearance.
b. Trying to cope with the changes of aging.
c. Denial concerning her advancing age.
d. Her fashion consciousness.

ANS: C

Some older people confront aging, whereas others deny it by acting in a younger manner.
5. According to Butler, a well-known gerontologist, ageism:

a. Dehumanizes the older individual.
b. Is based on the biologic theory of aging.
c. Is based on natural and purposeful occurrences.
d. Continues to change as the population ages.

ANS: A

Ageism is the stereotyping of and discrimination against people because of their age.

6. The nurse explains that the effects of aging on the nervous system result in:

a. Accelerated loss of neurons in the brain.
b. Gradually declining loss of intellectual capability.
c. Decreased conduction speed of neurons.
d. Loss of long-term memory.

ANS: C

Age-related effects on body systems are integral parts of the basis of nursing care for the older adult. The aging nervous system is characterized by decreased conduction speed of neurons.
7. The nurse includes in her approach to nursing care that older adult patients with mild cognitive impairment (MCI) are more likely to develop:

a. Dementia, non-Alzheimer type
b. Alzheimer dementia
c. Parkinson disease
d. Psychotic disorders

ANS: B

Approximately 40% of people with MCI will develop Alzheimer dementia within 3 years.

DIF: Cognitive Level: Analysis REF: p. 146 OBJ: 3

TOP: Physiologic Change KEY: Nursing Process Step: Implementation

MSC: NCLEX: Health Promotion and Maintenance: Prevention and early detection of disease

8. In planning activities to improve short-term memory for an older adult patient experiencing memory deficits, the nurse would:

a. Maintain the same daily schedule.
b. Rehearse memory training.
c. Provide a varied and stimulating daily schedule.
d. Conduct deep-breathing exercises.

ANS: B

Using mnemonics and memory rehearsal may improve memory performance in some older individuals.

DIF: Cognitive Level: Analysis REF: p. 146 OBJ: 3

TOP: Physiologic Change KEY: Nursing Process Step: Planning

MSC: NCLEX: Physiological Integrity: Physiological adaptation

9. The nurse reassures a patient who is worried about memory loss by using an example of normal memory change or lapse of memory such as:
a. Relying on another person to remember names or important events
b. Occasional forgetfulness or inability to recall names or facts
c. Difficulty in recalling recent events
d. Difficulty in recalling past events

ANS: B

Memory lapses such as forgetting a name or misplacing an item are common, normal memory changes.

DIF: Cognitive Level: Analysis REF: p. 146 OBJ: 3

TOP: Physiologic Change KEY: Nursing Process Step: Implementation

MSC:NCLEX: Psychosocial Integrity: Psychosocial adaptation

10. For most older adults, facts are that are generally accepted include:

a. Intellectual capabilities are impaired.
b. Functional brain activities decrease.
c. Functional intellectual capability is maintained.
d. Creativity and judgment are severely impaired.

ANS: C

Functional ability may not be significantly affected because reserve cells are able to compensate.

DIF: Cognitive Level: Analysis REF: p. 145 OBJ: 3

TOP: Physiologic Change KEY: Nursing Process Step: N/A

MSC:NCLEX: N/A

11. The nurse in a long-term care facility takes extra precaution in the approach to nursing care because the older adult is more prone to respiratory infection because of:

a. Decreased ciliary action
b. Decreased physical activity
c. Inadequate hydration
d. Poor personal hygiene

ANS: A
The ability to perform strenuous work decreases with age. The ciliary action responsible for movement of secretions from the lung is compromised because of epithelial atrophy.

DIF: Cognitive Level: Analysis REF: p. 146 OBJ: 3

TOP: Physiologic Change KEY: Nursing Process Step: Planning

MSC: NCLEX: Health Promotion and Maintenance: Prevention and early detection of disease

12. The nurse is aware that an older person whose renal changes make it impossible to concentrate or dilute urine is at risk for:

a. Urinary infection
b. Dehydration
c. Incontinence
d. Renal failure

ANS: B

The kidney’s ability to concentrate urine is a major defense against dehydration.

DIF: Cognitive Level: Analysis REF: p. 147 OBJ: 3

TOP: Physiologic Renal Change KEY: Nursing Process Step: Planning

MSC: NCLEX: Physiological Integrity: Physiological adaptation

13. Considering the gastrointestinal (GI) changes that take place in the geriatric patient, the assessment with the greatest priority to report is:

a. 24-hour urinary output of 1450 ml
b. 24-hour dietary intake of 75% of meals
c. Last bowel movement 4 days ago
d. Weight loss of 2 pounds since admission 2 months ago

ANS: C

GI changes include bloating, diarrhea, pernicious anemia, and constipation.

DIF: Cognitive Level: Analysis REF: p. 148 OBJ: 3

TOP: Physiologic Change KEY: Nursing Process Step: Assessment
14. The nurse assesses a major sign of renal changes related to age, which is: a. Hematuria
b. Nocturia
c. Urgency incontinence
d. Renal calculi

ANS: C
Urgency incontinence is related to several age-related changes in the urinary musculature. Renal calculi and hematuria are pathologic symptoms and are not age-related. Nocturia is not specifically related to aging.

DIF: Cognitive Level: Knowledge REF: p. 153 OBJ: 3
TOP: Physiologic Change KEY: Nursing Process Step: Assessment
MSC: NCLEX: Physiological Integrity: Physiological adaptation

15. When gathering data concerning the musculoskeletal system, the most significant assessment would be:

a. Slow gait
b. Degree of motion of all joints
c. Enlarged joints
d. Crepitus in joints

ANS: B
Determine mobility by assessing the range of motion in all joints; in addition, look for signs of inflammation and pain associated with mobility.

DIF: Cognitive Level: Analysis REF: p. 148 OBJ: 3
TOP: Physiologic Change KEY: Nursing Process Step: Assessment
MSC: NCLEX: Health Promotion and Maintenance: Prevention and early detection of disease
16. The nursing interventions appropriate for the patient with presbycusis would be:

a. Speak clearly and distinctly while facing the patient.
b. Announce your presence when entering the patient’s room.
c. Place needed articles within easy reach.
d. Orient the patient to time and place as needed.

ANS: A

Presbycusis is hearing loss. Get the patient’s attention so that the patient can concentrate on what you are saying or read lips.

DIF: Cognitive Level: Analysis REF: p. 149 OBJ: 3

TOP: Physiologic Change KEY: Nursing Process Step: Implementation

MSC: NCLEX: Physiological Integrity: Basic care and comfort

17. When the patient holds his Bible 6 inches from his face and turns his head to read out of the corner of his eyes, the nurse suspects that the patient is developing: a. Cataracts

b. Glaucoma
c. Presbyopia
d. Macular degeneration

ANS: D

The leading cause of new blindness in old age is macular degeneration, which results in the loss of central vision.

DIF: Cognitive Level: Analysis REF: p. 149 OBJ: 3

TOP: Macular Degeneration KEY: Nursing Process Step: Assessment

MSC: NCLEX: Physiological Integrity: Physiological adaptation

18. Chemosensory changes that are observed in the older adult:

a. Are directly related to the aging process.
b. Are most often caused by disease.
c. Begin in the fifth decade of life.
d. Affect more women than men.
Major changes in the ability to taste are often caused by disease or a side effect of certain drugs.

ANS: B

The nurse cautions family members that the final developmental stage is ego integrity. According to Erikson, if this stage is not mastered, the older adult will:

a. Have to repeat a previous stage.
b. Experience despair.
c. Be unable to advance past his or her present stage.
d. Experience disappointment.

ANS: B

The final developmental task is ego versus despair. This negative resolution is often seen as depression and social withdrawal.

DIF: Cognitive Level: Comprehension REF: p. 150 OBJ: 3

TOP: Psychosocial Factors KEY: Nursing Process Step: Implementation

MSC: NCLEX: Health Promotion and Maintenance: Growth and development

To relieve the discomfort of pruritus related to dry skin, the nurse should focus on:

a. Encourage the patient to talk to the primary care physician about the problem.
b. Encourage the patient to take a tepid bath and use moisturizers.
c. Teach the patient that pruritus is an expected consequence of aging.
d. Establishing a medication regimen to control the discomfort.

ANS: B

Because pruritus is caused by loss of oils in the skin, the patient should be encouraged to take tepid baths, use moisturizers, and avoid overuse of antiperspirants, soaps, perfumes, and long hot baths.
A new 72-year-old resident of a long-term care facility naps frequently during the day, stating that he is tired. The nurse should:

a. Obtain an order from the primary caregiver for a sedative.
b. Ask the patient if he is sleeping well at night.
c. Plan activities to keep the patient awake during the day.
d. Tell the patient that he cannot take any more naps.

ANS: B

Determining if or the reason why the patient is not sleeping at night will help the nurse implement the appropriate nursing actions. Depression may be interfering with adapting to the long-term facility.

The nurse is aware that drug toxicity can occur as a result of an age-related change in the liver, which is:

a. Increased liver size
b. Decreased liver enzyme activity
c. Rapid blood flow through the liver
d. Fluid accumulation in the portal vein

ANS: B

Decreased liver enzyme activity does not prepare the drug for excretion. The liver size is decreased in older persons; blood flow through the liver is also decreased.
23. A 77-year-old recently admitted to a long-term care facility refuses to join in activities or go to the dining room for meals. This behavior may indicate that the patient is: a. Stubborn
b. Depressed
c. Afraid
d. Tired

ANS: B

Some older people respond to loss by losing their sense of personal identity and fulfillment. They suffer from deterioration in self-esteem and become depressed.

DIF: Cognitive Level: Analysis REF: p. 151 OBJ: 5

TOP: Psychosocial Factors KEY: Nursing Process Step: Assessment

MSC:NCLEX: Psychosocial Integrity: Physiological adaptation

MULTIPLE RESPONSE

1. The error theories of aging are all based on the following concepts: (Select all that apply.)

a. Rate of aging is related to the rate of living.
b. Aging is a result of purposeful events governed by genetic structure.
c. External events cause damage to cells.
d. The organism becomes immune to the body’s restorative processes.
e. Cumulative damage causes organ malfunction.

ANS: A, C, E

Aging is a result of progressive damage to cells, which results in organ failure or error.

DIF: Cognitive Level: Analysis REF: p. 145 OBJ: 3

TOP: Aging Theories KEY: Nursing Process Step: N/A

MSC:NCLEX: N/A
2. The nurse assesses age-related cardiovascular changes that include: *(Select all that apply.)*

a. Cardiac murmurs  
b. Widened pulse pressure  
c. Pulse decreasing in force  
d. Dyspnea  
e. Chest pain  

ANS: A, B, C  

Murmurs, widening pulse pressure, and decreasing force of pulse are all associated with age-related changes. Dyspnea and chest pain are not anticipated changes in the cardiovascular system.